idea was worth including so that it would attract comment. The language itself may need further tweaking.

The need for uniform Federal health confidentiality legislation is clear. In a report titled ''Protecting Privacy in Computerized Medical Information,'' the Office of Technology Assessment found that the present system of protecting health care information is based on a patchwork quilt of laws. State laws vary significantly in scope and Federal laws are applicable only to limited kinds of information or to information maintained only by the Federal Government. Overall, OTA found that the present legal scheme does not provide consistent, comprehensive protection for privacy in health care information, whether that information exists in a paper or computerized environment. A similar finding was made by the Institute of Medicine in a report titled ''Health Data in the Information Age.''

A public opinion poll sponsored by Equifax and conducted by Louis Harris and Associates documents the importance of privacy to the American public. Eighty-five percent agree that protecting the confidentiality of people's medical records is absolutely essential or very important in national health care reform. The poll shows that most Americans believe protecting confidentiality is a higher priority than providing health insurance to those who do not have it today, reducing paperwork burdens, or providing better data for research. The poll also showed that 96 percent of the public agrees that it is important for an individual to have the right to obtain a copy of their own medical record.

Health information is a key asset in the health care delivery and payment system. Identifiable health information is heavily used in research and cost containment, and this usage will only grow over time. The Health Insurance Portability and Accountability Act of 1996 passed in the last Congress recognized that confidentiality legislation was essential to the fair management of health information. The law established a 3-year timetable for congressional action on confidentiality. That clock is ticking already, and we don't have much time to waste.

By establishing fair information practices in statute, the long-term costs of implementation will be reduced, and necessary protections will be uniform. This will assure patients and health professionals that fair treatment of health information is a fundamental element of the health care system. Uniform privacy rules will also assist in restraining costs by supporting increased automation, simplifying the use of electronic data interchange, and facilitating the portability of health coverage.

Today, few professionals and fewer patients know the rules that govern the use and disclosure of medical information. In a society where patients, providers, and records routinely cross State borders, it is rarely worth anyone's time to attempt to learn the rules of any one jurisdiction, let alone several jurisdictions. One goal of my bill is to change the culture of health records so that everyone will be able to understand the rights and responsibilities of all participants. Common rules and a common language will facilitate broader understanding and better protection. Physicians will be able to learn the rules once with the confidence that the same rules will apply wherever they practice. Patients will learn that they have the same rights in every State and in every doctor's office.

There are two basic concepts that are essential to an understanding of the bill. First, identifiable health information that is created or used during the health care treatment or payment process becomes protected health information, or individually identifiable patient information relating to the provision of health care or payment for health care. This new terminology emphasizes the sensitivity of the information and connotes an obligation to safeguard the data. Protected health information generally remains subject to statutory restriction no matter how it is used or disclosed.

The second basic concept is that of a health information trustee. Anyone who obtains access to protected health information under the bill's procedures becomes a health information trustee. Trustees have different sets of responsibilities and authorities depending on their functions. The authorities and responsibilities have been carefully defined to balance legitimate societal needs for data against each patient's right to privacy and the need for confidentiality in the health treatment process. Of course, every health information trustee has an obligation to maintain adequate security for protected health information.

The term trustee was selected in order to underscore that those in possession of identifiable health information have obligations that go beyond their own needs and interests. A physician who possesses information about a patient does not own that information. It is more accurate to say that both the record subject and the record keeper have rights and responsibilities with respect to the information. My legislation defines those rights and responsibilities. The concept of ownership of personal information maintained by third-party record keepers is not particularly useful in today's complex world.

A key element of this system is the specification of the rights of patients. Each patient will have a bundle of rights with respect to protected health care information about himself or herself that is maintained by a health information trustee. A patient will have the right to seek correction of information that is not timely, accurate, relevant, or complete. A patient will also have the right to expect that every trustee will use and maintain information in accordance with the rules in the Act. A patient will have a right to receive a notice of information practices. The bill establishes standards and procedures to make these rights meaningful and effective.

I want to emphasize that I have not proposed a pie-in-the-sky privacy code. This is a realistic bill for the real world. I have borrowed ideas from others concerned about health records, including the American Health Information Management Association, the Workgroup for Electronic Data Interchange, and the National Conference of Commissioners on Uniform State Laws. Assistance provided by the American Health Information Management Association [AHIMA] was especially helpful in the development of this legislation several years ago. AHIMA remains a valuable source of knowledge on health records policies and an ardent supporter of Federal health privacy legislation.

I believe that we do not have the luxury of elevating each patient's privacy interest above every other societal interest. Such a result would be impractical, unrealistic, and expensive. The right answer is to strike an appropriate balance that protects each patient's interests while permitting essential uses of data under controlled conditions. This should be happening today, but record keepers do not know their responsibilities, patients rights are not always clearly defined, and there are large gaps in legal protections for health information.

My bill recognizes necessary patterns of usage and combines it with comprehensive protections for patients. There will be no loopholes in protection for information originating in the health treatment or payment process. As the data moves to other parts of the health care system and beyond, it will remain subject to the Fair Health Information Practices Act of 1997. This may be the single most important feature of the bill.

The legislation includes several remedies that will help to enforce the new standards. For those who willfully ignore the rules, there are strong criminal penalties. For patients whose rights have been ignored or violated by others, there are civil remedies. There will also be administrative sanctions and arbitration to provide alternative, less expensive, and more accessible remedies.

The Fair Health Information Practices Act of 1997 offers a complete and comprehensive plan for the protection of the interests of patients and the needs of the health care system in the complex modern world of health care. More work still needs to be done, and I am committed to working with every group and institution that will be affected by the new health information rules. I remain open to new ideas that will improve the bill.

In closing, I want to acknowledge the limits of legislation. We must recognize and accept the reality that health information is not completely confidential. It would be wonderful if we could restore the old notion that what you tell your doctor in confidence remains absolutely secret. In today's complex health care environment, characterized by third party payers, medical specialization, high-cost care, and increasing computerization, this is simply not possible. My legislation does not and cannot promise absolute privacy. What it does not offer is a code of fair information practices for health information.

The promise of that code to professionals and patients alike is that identifiable health information will be fairly treated according to a clear set of rules that protect the confidentiality interests of each patient to the greatest extent possible. While we may not realistically be able to offer any more than this, we surely can do no less for the American public.

THE COMMUNITY PROTECTION ACT OF 1997

HON. RANDY ''DUKE'' CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. CUNNINGHAM. Mr. Speaker, Americans want us to work together to sensibly combat crime. Putting more, better-equipped and fully trained cops on the beat can be a strong part of any anticrime effort. It is for that very reason that today I am introducing the Community Protection Act of 1997.

The bill will allow qualified, properly trained active and retired law enforcement officers to carry concealed handguns. Too often State

laws prevent highly qualified officers from assisting in crime prevention and protecting themselves while not on duty. For example, a man who has spent his life fighting crime is often barred from helping a colleague in distress because he cannot use his service revolver—a handgun that he is required to train with on a regular basis. That same officer, active or retired, isn't allowed to defend himself from the criminals that he put in jail.

My bill seeks to change that by empowering qualified law enforcement officers to be equipped to handle any situation that may arise, wherever they are.

The community protection initiative covers only active duty and retired law enforcement personnel who meet the following criteria:

First, employed by a public agency—security guards are not covered.

Second, authorized by that agency to carry a firearm in the course of duty—all beneficiaries will have received firearms training and appropriate screening.

Third, not subject to any disciplinary action.

Retired police officers must meet all of these criteria and have retired in good standing.

In the tradition of less government, this bill offers protection to police officers and to all of our communities without creating new programs or bureaucracies, and without spending more taxpayer dollars.

Because this is a sensible, nonpartisan bill, it gained tremendous support in the 104th Congress. By the close of legislative business, the Community Protection Act was cosponsored by more than 130 Members of the House from both parties and from all regions of the country. It also gained the interest of the Crime Subcommittee, which held a hearing on the bill in July 1996.

I am proud to once again introduce this important piece of legislation and look forward to working with my colleagues to pass it as soon as possible.

THE NOTCH BABY ACT OF 1997

HON. JO ANN EMERSON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mrs. EMERSON. Mr. Speaker, today I am introducing long-overdue legislation to correct an injustice done to well over 6 million senior citizens by the Social Security Amendments of 1977. My legislation, the Notch Baby Act of 1997, will adopt a transitional computation method to assure that America's ''Notch Babies'' born between 1917 and 1921 receive equitable Social Security benefits.

Contrary to what many think, Mr. Speaker, the Social Security Notch is a simple problem that is greatly in need of an obvious solution. Seniors born in the 5-year period after 1916 have seen lower average Social Security benefit payments than those born shortly before or after. This disparity is directly attributable to the revised benefit calculation formula that resulted from the Social Security Amendments of 1977. The facts are clear and Congress must take action to correct this unintended error.

In December 1994, the Commission on the Social Security Notch issued its final report and recommendation to Congress. The commission cited an example of two workers who retired at the same age with the same average career earnings. One of these workers was born on December 31, 1916. The other was born 48 hours later, on January 2, 1917. If both retired in 1982 at age 65, the worker born in 1917 would receive $110 less in monthly Social Security benefits. And yet the Commission on the Social Security Notch concluded that ''benefits paid to those in the 'Notch' years are equitable, and no remedial legislation is in order.'' Mr. Speaker, I beg to differ. One-hundred and ten dollars per month represents a lot of money to any family, but even more so to the millions of retirees who live on a limited, fixed monthly income.

The time for Congress to take action to correct the ''Notch'' injustice is long overdue. I urge all of my colleagues to review the Notch Baby Act of 1997 and cosponsor this important piece of legislation.

A BEACON-OF-HOPE FOR ALL AMERICANS: DR. RUBIE M. MALONE

HON. MAJOR R. OWENS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. OWENS. Mr. Speaker, with the 1996 election behind us, this Nation has completed another cycle for the ongoing democratic process which makes America great. The electoral process and the public officials selected through this process are invaluable assets in our quest to promote the general welfare and to guarantee the right to life, liberty, and the pursuit of happiness. It is important, however, Mr. Speaker, that we also give due recognition to the equally valuable contribution of nonelected leaders throughout our Nation. The fabric of our society is generally enhanced and enriched by the hard work done year after year by ordinary volunteer citizens. Especially in our inner city communities which suffer from long public policy neglect, local grassroots leaders provide invaluable service. These are men and women who engage in activities which generate hope. I salute all such heroes and heroines as Beacons-of-Hope.

Currently, the dean, director and chairperson of the SEEK program at CUNY's John Jay College of Criminal Justice, Dr. Rubie Malone has tirelessly dedicated her life to making our society better. She is directly responsible for community enhancement efforts that impact education, social/human services, and health care.

Dr. Malone's civic contributions began at an early age when she began working with high school seniors at Bethany Baptist Church. After transferring to the Church of the Evangel United Church of Christ, she continued working with youth and adult groups. In the Brooklyn Alumnae Chapter of Delta Sigma Theta Sorority, Inc., she has served as president and second vice-president and coordinator of committees and projects including School America, voter registration, health fairs, book and college fairs, teen lift, social action and political awareness, and oratorical contests. She is a member of the Brooklyn Chapter of Links, Inc., where she serves as parliamentarian and is involved in various community projects. Dr. Malone is also a former president of jack and Jill of America.

Dr. Rubie Malone, who is the eldest of twelve children, received a bachelor of science in mathematics from Clark College; a master's degree from CUNY's Hunter College; and a doctorate of philosophy in social services from Columbia University.

Rubie Malone is a Beacon-of-Hope for central Brooklyn and for all Americans.

HOUSE SHOULD ELECT INTERIM SPEAKER

HON. NEIL ABERCROMBIE

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. ABERCROMBIE. Mr. Speaker, article I, section 2 of the Constitution requires the House of Representatives to choose a Speaker. It is customary at the commencement of every Congress for members of each party to vote for the candidate decided upon by his or her caucus. Because governance of the House conforms to the democratic principles which undergird our Republic, there is no doubt that the votes of the majority will determine who shall be our Speaker.

Today, however, we are choosing a presiding officer in unprecedented circumstances. Never before has there been an election for Speaker in which one of the candidates stands formally accused by the Committee on Standards of Official Conduct of violating the rules of the House. It is not my intention today to argue the merits of the charges against the gentleman from Georgia or what if any sanctions should be imposed. I focus instead on the implications of the committee's statement of alleged violation for today's election for Speaker, for the Speakership as an institution, for the House of Representatives, and for our Nation itself.

The facts are these: The Committee on Standards of Official Conduct alleges that the gentleman from Georgia violated the rules of the House. As of this date the committee has not completed its consideration of the case, and no resolution has been achieved. When resolution does occur, it may very well involve sanctions which make the gentleman from Georgia ineligible to hold the post of Speaker.

Removal of a Speaker under those conditions would be debilitating for the House and the Nation. It would cause chaos within the House and further undermine public confidence in democratic institutions. Even if resolution of the case against the gentleman from Georgia does not result in his ineligibility for the Speakership, his election as Speaker at this time would be inadvisable for two reasons: No. 1, the time, attention, and energy he must devote to his case will diminish the personal resources available for the discharge of his duties as Speaker of the House; and No. 2, the shadow of doubt and suspicion cast by the proceedings against him will undoubtedly fall on every action of the House and bring into question the integrity of this institution.

I believe, therefore, that until the case against the gentleman from Georgia is resolved, the House should choose an interim Speaker. I reiterate my acknowledgement that the majority has the right to determine who that individual shall be. However, in order to ensure that the business of the House is conducted in an undistracted manner, free of